People with mental illnesses are greatly overrepresented in our prisons. Prisoners are two to three times as likely as those in the community to have a mental illness and are ten to 15 times more likely to have a psychotic disorder. Our research suggests one in three people taken into police custody are likely to be receiving psychiatric treatment at the time. If you include those with a substance misuse disorder, the numbers increase even further.

Prisoners with mental illnesses often do not adapt well to prison. They are more likely to be at risk for suicide and to present management difficulties for prison staff.

A high percentage of prisoners are on remand awaiting sentence and most receive relatively short sentences, so we need to consider the continuity of mental health care from the community, through the period of incarceration and back in the community upon release.

To this end, entry into the justice system can be viewed as a public health opportunity to identify those with mental illnesses and provide treatment that will continue upon release to the community.

Better identifying and addressing these mental health needs not only helps those receiving care and their families, it may also reduce incarceration rates, benefiting the whole community.

**Better screening and identification**

There are many entry points to the justice system. At each point, a mechanism is required to identify those with a serious mental illness.

Most importantly, people entering police custody and prisons must be screened to identify symptoms of mental illness. Unfortunately, it is not uncommon for mental illnesses to be first identified on admission to prison. For those with previously diagnosed disorders, their treatment needs must be identified to ensure they continue to receive care.

All states routinely undertake mental health screening on admission to prison, although the practices vary widely. Best practice in prison mental health screening requires a standardised reception screening measure, used by a mental health professional.

Less screening and identification of mental health conditions occurs at other points of entry to the justice system.

**Community diversion**

Many people entering custody have received mental health treatment in the community, raising the question of why we don’t divert more mentally ill individuals from custody to community mental health services.

Our own research shows that almost a third (32%) of detainees being taken into police custody in Victoria were receiving psychiatric treatment in the community at the time of being arrested. Of these people, half (17%) were being treated by a public mental health service.

Court-based mental health services offer great opportunity to intervene for people who do not go into police custody or prison. New South Wales, for example, has been gradually expanding court and custodial diversion of mentally ill individuals. Most diversions come from the courts to community mental health services, with a smaller number of diversions coming from custody. The state is now diverting around 2,000 people per year.
Diversion is one of the best strategies for keeping people with mental illnesses out of the justice system. This, of course, raises concerns about the capacity of community mental health services.

However, not all people are suitable for diversion. Entry into such programs must be dependent on the person’s charges and behaviour.

**Services in prisons**

When it comes to mental health care, the proverbial buck stops with prisons. Medicare does not extend to prisoners, so all in-custody mental health services must be funded within state health and justice budgets.

The standard for prisoner mental health care should be equivalent to that which is expected in the community. But while community and inpatient services may turn away patients, the same is not true for prisons.

In a number of states, prison health and mental health services are funded by justice, not health. This amplifies the disconnect between community and prison-based services and represents a lost opportunity for the provision of services and for the continuity of care.

Services within prisons require a mix of providers, including general practitioners, mental health nurses, clinical psychologists, allied mental health staff and psychiatrists. Most prisoners with mental illnesses can be managed in mainstream settings in the prison, receiving what is termed “outpatient” services.

However, clear pathways and services must enable prisoners to voluntarily escalate to more specialist care. Specialist mental health units currently operate in large reception prisons in Melbourne and Sydney, with hundreds of admissions annually.

Options must also be available to transfer prisoners requiring involuntary hospitalisation to forensic hospitals or other appropriate mental health units in hospitals. This is an incredibly challenging matter since it is common for prisoners to be held in prisons, certified for transfer to hospital, but unable to leave the prison due to a lack of hospital beds in the community.

Prisons also require so-called “step down” units that enable prisoners with mental illnesses to transition from specialist mental health units to mainstream units.

**Care on release from custody**

All too often, prisoners with mental illnesses are released without the arrangement of appropriate follow-up care and without the psychiatric medication necessary to maintain their mental health.

While many states offer transitional care, this is an area that requires much greater coordination and resources. When prisoners are released from custody, even if discharge care and planning is arranged, they can nonetheless be all too easily lost to contact, only to have them deteriorate and re-engage in the behaviour for which they were initially incarcerated.

**Mental health of ATSI prisoners**

A common theme throughout this series on the state of Australian prisons is the over-representation of Aboriginal and Torres Strait Islander (ATSI) prisoners.

The difficulties with mental illness are compounded in the ATSI population. Recent research in Victoria revealed that 72% of male Aboriginal prisoners and 92% of female Aboriginal prisoners met the criteria for a diagnosis of a major mental illness. This research parallels similar findings in Queensland, New South Wales and Western Australia.

Victoria has recently released an Aboriginal Social and Emotional Wellbeing Plan to better address the mental health needs of Aboriginal prisoners. Other states have developed plans but clearly much more needs to be
Careful planning

To be most effective, the delivery of mental health care in custodial settings needs to be carefully planned with a statewide approach that forms part of a comprehensive forensic mental health service.

Although not mentioned above, services are required for other populations, including female prisoners who have even higher rates of mental illness. The mental health needs of culturally and linguistically diverse prisoners also present challenges.

While the states are struggling with increasing numbers of prisoners, great promise exists to divert large numbers of people with mental illnesses out of prisons, and to provide greater care to those in custody and on release from prison.

You can read other articles in the State of Imprisonment series here.